PRINTED: 07/18/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONST	FRUCTION	(X3) DATE SURVEY COMPLETED		
		17E596	B. WING _			07/18/2014	
	ROVIDER OR SUPPLIER			331 SW	ADDRESS, CITY, STATE, ZIP CODE OAKLEY A, KS 66606		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	S	FC	000			
F 274 SS=D	Health Resurvey an KS00072686 and K	MPREHENSIVE ASSESS	F 2	274			
33-D	A facility must conduses assessment of a restacility determines, of that there has been resident's physical opurpose of this sect means a major declaresident's status that itself without further implementing standinterventions, that hone area of the resident requires interdisciplicate plan, or both.)  This REQUIREMENT by: The facility identifies The sample include observation, record	uct a comprehensive sident within 14 days after the or should have determined, a significant change in the or mental condition. (For ion, a significant change ine or improvement in the it will not normally resolve intervention by staff or by ard disease-related clinical as an impact on more than dent's health status, and inary review or revision of the					
	Findings included:	34) of the sampled residents.					
	3/14/14 for resident Interview for Mental indicating moderate displayed hallucinat	#34 revealed a Brief Status (BIMS) score of 11, cognitive impairment. He/she ions (sensing things while			TITLE		(Ve) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DAT

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 274	created) and delusic perception held by a shows it was untrue independent with be in his/her room, wal locomotion on the u unit. He/she require dressing and toilet up for personal hygicassistance from 1 stresident was freque always continent of The Quarterly MDS score of 12, indicating impairment. He/she delusions. The resident mobility, transfe walking in the corridand locomotion off the supervision for dress He/she required state assistance for personal staff set up assistant was always contined. Comparison of the 2 more changes in the living (ADLs) abilitie status.	o be real, but the mind ons (untrue persistent belief or a person although evidence). The resident was an additional mobility, transfers, walking king in the corridor, init, and locomotion off the ed staff supervision for use, staff supervision and set ene and eating, and extensive that member for bathing. The intly incontinent of bladder and	F 2	<u> </u>			
	revealed staff provice for brushing his/her bathing, and washing Staff provided assist related to the reside	led prompting to the resident teeth, changing clothes, g his/her hands after voiding. tance with ADLs as needed nt's weakness due to low aplaints of weakness.					

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F 274	Continued From paç	ge 2	F 2	774			
	sat on the couch in television.  Interview on 7/15/14 nursing staff H reveresponsible for com assessments. Staff complete the assess verbally notified the observed changes at Interview on 7/15/14 administrative nursing completed the MDS reported if the reside different areas lasting he/she completed at 15/14 administrative nursing completed at 15/14 administrative nursing completed the MDS reported if the reside different areas lasting he/she completed at 15/14 administrative nursing com	H expected him/her to sments correctly and he/she MDS coordinator of any as needed.  H at 9:39 A.M. with any staff E revealed he/she is for the residents. He/she ent had a change in 2 any more than 2 weeks then					
	persistent over 2 we	eks, not just the 7 day look e/she would complete a ssessment.					
	expected staff to co	ng staff D revealed he/she mplete a significant change dent met the criteria.					
	regarding the reside significant change a staff when it was de a significant decline physical, mental, or when the resident's	ey provided by the facility on tassessment revealed a ssessment was completed by termined that the resident had or improvement in their psychosocial condition, or status changed to the extent of care no longer reflected s.					

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F 274	assessment for this re cognitive impairment, in bathing and eating bladder continency st	omplete a significant change esident with moderate who showed improvements abilities, and a change in atus.	F	274			
F 279 SS=D		CARE PLANS e results of the assessment d revise the resident's	F	279			
	plan for each resident objectives and timeta medical, nursing, and	elop a comprehensive care t that includes measurable bles to meet a resident's mental and psychosocial ied in the comprehensive					
	to be furnished to atta highest practicable ph psychosocial well-bei §483.25; and any ser be required under §48 due to the resident's a						
	by: The facility identified The sample included observation, record re facility failed to developlan that was individu	a census of 48 residents. 11 residents. Based on eview, and interview the pa comprehensive care residents to the residents's resident #13 for individual					

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F 279	coping skills, #41 for Findings included:  Resident #13's July sheet (POS) recorded to the facility on 5/28/schizophrenia (a psychygross distortion of language and common of thought, perception  The admission Minimassessment dated 6/could not complete a status which indicated was severely impaire resident exhibited the screaming and yelling review period, require activities of daily livin dressing, toilet use and daily pain at a level of being extreme). This documented the residenti-depressant (mediof sadness) and anti-decrease a resident's The 6/10/14 admission (CAA) for behavior and recorded the resident interrupted his/her about an and dramatically upser peers with screaming others.  The resident's care period.	nutrition and #35 for bathing.  7 2014 physician's order d the resident was admitted f14 with a diagnosis of chotic disorder characterized reality, disturbances of unication and fragmentation in and emotional reaction).  num Data set 3.0 (MDS) 6/14 recorded the resident Brief Interview for Mental d the resident's cognition d. The MDS recorded the eatening behaviors, g at others daily during the ed limited assistance with g in effect, mobility, ind personal hygiene, had if 6 on 1 to 10 scale (10 same assessment dent received lication to alleviate feelings anxiety (medication to s stress level) medications. on Care Area Assessment ind psychosocial adjustment it's behavior severely willity to interact with others et the living environment and in, cursing, and threatening	F2	279			
		dents would be compliant ons 100 percent of the time					

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F 279	coping skill by 7/9/14 staff to attempt to each his/her medications anger management.  The care plan lacked specific methods use regarding his/her medicidualized coping resident's disruptive.  Observation at varioo 7/10/14 at various to 4:00 P.M. the reside appearance, ambula from the dining room scolding in an aggreand other residents.  On 7/10/14 at 8:30 Anursing staff D state by the team, MDS consoial services, and An interim care plan was first admitted to 14 day period when and then staff met at comprehensive care admission. Administ stated the nursing staff care plans as applications.  The 2012 Care Plan policy documented to interventions to mee resident goals," and	s and would identify one new 4. The care plan directed lucate the resident about and teach skills to help with and mood regulation.  d documentation of any ed to educate the resident edications and/or g strategies to deal with the behaviors.  us times on 7/9/14 and mes between 7:40 A.M. and int had an unkempt iting in the halls and to and in, yelling, cursing, and ssive manner toward staff  A.M. administrative licensed d care plans were developed cordinator, activity director, dietary, and reviewed weekly. was done when the resident the facility and; there was a staff assessed the resident	F 279			

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F 279	The facility failed to care plan with interresident's goals of and using individua cognitively impaired disorder.  - Resident #41's Jusheet (POS) record with a diagnoses of disease condition the irreversible damage (kidney).  The annual Minimusesessment dated that a Brief Interviewhich indicated the intact. The MDS reclimited assistance with mobility, dressing, thygiene. The asset the resident receives method of blood put the 6/23/14 Care Acognition recorded could affect his/her follow his/her diet recorded disease cause phosphorous and part of the care and	ween the MDS and Care Plan."  I develop a comprehensive ventions designed to meet the compliance with medications I coping skills for this I resident with a mental I coping skills for this I resident with a mental I coping skills for this I resident with a mental I coping skills for this I resident with a mental I coping skills for the resident was admitted I coping skills for the resident was terminal because of the to vital tissues or organs  I coping skills for this I coping skills for the resident was admitted I coping state of the resident personal coping state of the resident required with activities of daily living for collet use and personal companies and personal companies (a mechanical coping state of the resident's renal disease cognition when he/she did not	F 2'	79		

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F 279	containing these ith his/her diet. The respect of the registrated if he/she did not follow his/he intake of a regular foods, and staff off every evening.  The care plan date documentation of the need to limit for his/her non-complibility protein snacks supplements.  Observation on 7/1 resident was in the approximately 70 p. On 7/15/14 at 2:00 he/she was not on have whatever he/received enough for the team, MDS social services, diese and supplements.	d watch intake of foods ems but he/she did not follow esident received protein but refused them as well as oplement for residents with e/she received encouragement taff.  stered dietician note dated es the resident refused weight d food preferences, became lid not get what he/she wanted, er diet, staff encouraged good diet, limited high potassium ered a protein supplement  d 7/10/14 lacked he resident's nutritional status, ods containing potassium, ance with his/her diet, his/her s, and use of dietary  10/14 at 12:00 P.M the e main dining room and ate bercent of his/her lunch.  P.M. the resident stated any diet restrictions, could she wanted, and stated he/she	F 279				

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F 279	met and developed a within 30 days of adr licensed nurse D stat the residents' care pl resident's care needs The 2012 Care Plant policy documented the Care Area Assest triggers which serve and Care Plan."  The facility failed to care plan that include (diet, restrictions, use for this resident who interventions.	the resident and then staff a comprehensive care plan mission. Administrative ted the nursing staff updated ans as applicable to the state of the care plan would "consider sments (CAA) and care area as a link between the MDS develop a comprehensive and nutritional information are of supplements, etcetera) required nutritional	F 2'	79			
	- The Quarterly Minimum Data Set 3.0 (MDS) dated 5/16/14 for resident #35 revealed a Brief Interview for Mental Status score of 15, indicating no cognitive impairment. The resident displayed symptoms of delirium (sudden severe confusion, disorientation and restlessness), had delusions (untrue persistent belief or perception held by a person although evidence showed it was untrue), and had hallucinations (sensing things while awake that appeared to be real, but the mind created). He/she also displayed verbal behavioral symptoms directed towards others 4 to 6 days of the look back period. The resident was independent with bed mobility, transfers, walking in his/her room, walking in the corridor, locomotion on the unit, locomotion off the unit, and toilet use. He/she required supervision from staff for eating, bathing, and personal hygiene. The resident required limited physical assistance from 1 staff member for dressing.						

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F 279	Activities of Daily Lirsupervised the resident provided encour ADLs and bathe as periods of not wanticaring for his/hersel.  The ADL care pland revealed staff provided and set up related to items needed for perbrush.  The care plan lacked the resident's bathing.  The monthly summate the resident was incomediated and "does most of { The resident was about the resident was about the staff R revealed he/resident's preference interview on 7/14/12 staff R revealed he/resident's preference interview on 7/14/14 nursing staff H revealed him/herself up bathroom. At times shop to wash his/heresident with supplied the s	ea Assessment (CAA) for ving (ADLs) revealed staff dent during meals for safety ragement to perform his/her needed. The resident had ng to bathe or adequately f.  with a revision date of 6/20/14 ded the resident with cueing to bathing. The staff provided presonal hygiene such as a hair and individualization regarding ng preferences.  ary signed 6/23/14 revealed dependent with his/her ADLs his/her} clean up in the sink." tolle to make his/her needs  0/14 at 4:08 P.M. revealed the lie in the dining room actively oup craft activity.  5 at 4:04 P.M. with direct care she was unsure of the es regarding showering.  4 at 4:22 P.M. with licensed alled the resident preferred to to at bedside or in his/her the resident used the beauty or hair. Staff provided the es such as washcloths, Staff H was unsure if he/she	F 279		

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F 279	Interview on 7/15/14 nursing staff H reveal update the care plan unsure which staff m comprehensive care  Interview on 7/15/14 staff T revealed the r him/herself up in his/ staff provided the resup in his/her room su preferred to use his/r reported the resident wanted to use the ac staff provided set up  Interview on 7/15/14 resident revealed he	expect staff to individualize resident.  at 7:58 A.M. with licensed alled all nurses were able to a. Staff H reported he/she was dember developed the plan.  at 7:59 A.M. with direct care resident usually cleaned with reported sident with supplies for clean and as towels but the resident her own shampoo. Staff T to notified staff if he/she citual shower room and the assistance.  at 8:08 A.M. with the with the resident preferred to wash	F 2	<u> </u>			
	reported he/she wou he/she desired to us lnterview on 7/15/14 staff S revealed the with his/her cares an his/her needs. Staff staff to individualize resident since they with the staff to individualize resident since the staff to individualize	at 8:19 A.M. with direct care resident was independent d was able to verbalize S stated he/she expected the care plan for each were all so different.					

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F 279 F 309 SS=D	expected staff to indive each resident.  The January 2012 poregarding care planni comprehensive care each resident and ad individual needs, streeth facility failed to dindividualized care planting preferences.  483.25 PROVIDE CAHIGHEST WELL BEIL Each resident must reprovide the necessari or maintain the higher mental, and psychosolaccordance with the dand plan of care.  This REQUIREMENT by: The facility identified The sample included observation, record refacility failed to performant care provided to performant in the provided to performan	at 11:29 A.M. with g staff D revealed he/she yidualize the care plan for licy provided by the facility ng revealed a plan must be developed for dress the residents' ngths, and preferences. evelop a comprehensive, an for this resident regarding RE/SERVICES FOR NG eceive and the facility must y care and services to attain st practicable physical,		309			
	Findings included:						

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F 309	dated 6/12/14 for resof paranoid schizoph characterized by grod disturbances of lang and fragmentation of (violent involuntary signoup of muscles).  The annual Minimum Assessment Referenthe residenthad a B Status of 15 and had belief or perception evidence showed it independent with bein the room and the off the unit, dressing supervision with perwas steady at all times ated to a standing when turning around direction while walking surface transfers, had motion, was always bladder, and had no assessment.  The Care Area Asserevealed the resider falls due to use of characterized by a gent and fall	sian's Order Sheet (POS) sident #3 revealed diagnoses brenia (psychotic disorder best distortion of reality, uage and communication of thought), and seizures beeries of contractions of a  In Data Set 3.0 with an once Date of 6/20/14 revealed orief Interview for Mental of delusions (untrue persistent oneld by a person although owas untrue). He/she was of mobility, transfers, walking corridor, locomotion on and of, and toilet use, required osonal hygiene and eating, ones when moving from a of position, when walking, order and facing the opposite order of bowel and	F3	09			
	treat anxiety-mental characterized by app irrational fear) and the/she also had an	or emotional reaction or emotional reaction or ehension, uncertainty and neir potential side effects. increased risk due to the enia on his/her cognition.					

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F 309	Continued From pa	ge 13	F 309		
	7/4/14 revealed the nurse on duty and he cheek and left knee 9/3/13 interventions footwear, ensure the and ensure good lig interventions were used to be a considered and ensure good lig interventions were used to be a considered and ensure good lig interventions were used to be a considered and ensure good lig interventions were used to the resident about using night light was on, e on the resident more frequently for pain.  An interview on 7/9/nursing staff H revefall on 7/4/14 stating blankets at night who bathroom. The fall was resident received and cheek.  Accident investigation facility lacked evided (assessment of senresponses, especial whether the nervous on 7/10/14 at 2:56 lobserved ambulatin with a steady gait.  On 7/10/14 at 7:38 and dining room and aterview of the cheek gait.	resident reported a fall to the ad an abrasion to the right. Prior to the 7/4/14 fall, the were to ensure proper e call light was within reach, hiting. After the fall on 7/4/14, updated to re-educate the goal the call light, ensure the ensure good footwear, check are frequently, and reassess.  14 at 11:01 A.M. with licensed alled the resident reported a goal he/she got tangled in the len he/she got up to go to the was not witnessed and the en abrasion to his/her left.  In information provided by the ence of neurological checks.  It is calcalled the resident was go in the hallway independently.  P.M. the resident was go in the hallway independently.  A.M. the resident sat in the ence of p.M. with direct care.  It at 3:07 P.M. with direct care.			

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F 329 SS=E	staff P revealed when assisted the nurse w for pain.  Interview on 7/14/14 nursing staff H reveal their head he/she did facility's protocol. Lid acknowledged he/she checks when this reson 7/4/14.  Interview on 7/14/14 administrative nursin resident fell and hit the neurological checks.  The policy for fall ma 2012 provided by the performing neurological who fell and hit his/her the facility failed to pand thoroughly assess his/her head during a 483.25(I) DRUG RECUNNECESSARY DRECUNNECESSARY	at 3:09 P.M. with licensed alled if a resident fell and hit is neurological checks per the censed nursing staff H e did not initiate neurological sident fell and hit his/her head at 4:35 P.M. with g staff D revealed anytime a neir head, nursing staff did anagement revised August e facility did not address cal checks for a resident er head.  Derform neurological checks as this resident who hit a fall.  GIMEN IS FREE FROM RUGS  Tegimen must be free from An unnecessary drug is any excessive dose (including r for excessive duration; or onitoring; or without adequate er, or in the presence of the swhich indicate the dose r discontinued; or any	F3			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E596	B. WING		07/18/2014	
	ROVIDER OR SUPPLIER  N PLACE WEST		STREET ADDRESS, CITY, STATE, ZIP CODE  331 SW OAKLEY  TOPEKA, KS 66606			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION	
F 329	resident, the facility r who have not used a given these drugs un therapy is necessary as diagnosed and do record; and residents drugs receive gradua behavioral intervention	ensive assessment of a nust ensure that residents ntipsychotic drugs are not less antipsychotic drug to treat a specific condition ocumented in the clinical who use antipsychotic all dose reductions, and	F 32	9		
	by: The facility identified The sample included observation, record r facility failed to consi movements, behavio medications for 5 of s unnecessary medica #38), failed to consis levels and have para monitoring for 1 of 5 unnecessary medica monitor the effectiver 5 residents reviewed medications (#38).  Findings included:  - The signed Physici resident #6 dated 6/1	I a census of 48 residents.  11 residents. Based on eview, and interview, the stently monitor bowel rs, and side effects of residents reviewed for tions (#6, #25, #28, #34, and tently monitor blood sugar meters for blood sugar residents reviewed for tions (#6), and failed to hess of an antibiotic for 1 of for unnecessary				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI	PLE CONSTRUCTION  IG	' '	(X3) DATE SURVEY COMPLETED	
		17E596	B. WING _			07/18/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 331 SW OAKLEY TOPEKA, KS 66606	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL : LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 329	of thought), constipations stools), depression (characterized by examples, worthless diabetes mellitus (which is the stools).	uunication and fragmentation tion (difficulty passing abnormal emotional state aggerated feelings of less and emptiness), and nen the body cannot use	F 3	29		
	cannot respond to the The annual Minimum Assessment Reference revealed the resident (moderate cognitive hallucinations (sensive appear to be real, but delusions (untrue perheld by a person alther the temperature).	insulin made or the body the insulin). In Data Set (MDS) with the three Date (ARD) of 3/28/14 It had a BIMS score of 9 Impairment). He/she had Ing things while awake that Ing the mind created), and Insistent belief or perception Inough evidence showed it Insulin				
	behaviors, received antipsychotic (medical major mental disorder impairment in reality (medication to treat reaction characterized uncertainty and irrational antidepressant (medical medical	injections, insulin, sation to treat psychosisany er characterized by a gross testing), antianxiety anxietymental or emotional ed by apprehension, ional fear), and dication to treat symptoms of				
	The Care Area Asse psychotropic drug us resident had a long I starting at age 16 ar medications to contr such as depression behaviors these cau monitoring for the ef	ys of the look back period.  ssment (CAA) for se dated 4/9/14 revealed the history of mental illness ad required psychotropic ol symptoms of the illness and psychosis as well as sed. He/she needed				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E596	B. WING		07/18/2014	
	ROVIDER OR SUPPLIER  N PLACE WEST	•	STREET ADDRESS, CITY, STATE, ZIP CODE  331 SW OAKLEY  TOPEKA, KS 66606			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 329	resident received dimedications that has constipation. Nursi (a stool softner) per blood glucose level provided dietary fibisigns and symptom and checked the resigns and symptom were present.  The care plan updaresident received dietary fibisigns and symptom were present.  The care plan updaresident received dietary for signs or reactions. Staff encompliant with med monitored for signs effects related to midications per phorocal mouth (PO) every rordered 7/25/10, Zomedication) 100 mg depression ordered antipsychotic medic for schizophrenia ordered 1/26/13, Climedication) 1 mg Pschizophrenia ordered solventia solventia ordered schizophrenia ordered schi	atted 7/4/14 revealed the aily doses of psychotropic of the potential for ng staff administered Colace physician's orders, monitored sper physician's orders, er as needed, monitored for so of high and low blood sugar, sident's blood sugar if any so of high or low blood sugar of high or low blood sugar and needed staff to symptoms of adverse couraged him/her to remain ications and lab draws, staff or symptoms of adverse edications, and provided sysician's orders.  So revealed orders for Abilify (an eation) 30 milligrams (mg) by morning for schizophrenia ploft (an antidepressant of 2 tablets PO daily for 18/27/08, Clozapine (an eation) 100 mg PO twice a day ordered 1/26/13, Clozapine 100 bedtime for schizophrenia onazepam (an antianxiety	F 329			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 331 SW OAKLEY TOPEKA, KS 66606	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION
F 329	Continued From pag	ge 18	F 329	e e e e e e e e e e e e e e e e e e e	
	inconsistent and ina day and 1 of 30 eve monitoring documer evening shifts lacked documentation and side effect monitorin four of 30 days and inaccurate side effect.  The May 2014 beha inconsistent and ina days lacked behavior. Thirty-one of 31 even documentation for so of 31 day shifts lack effect monitoring. To	vior charting revealed ccurate charting. Nine of 30 ning shifts lacked behavior station. Thirty of 30 night and diside effect monitoring 14 of 30 day shifts lacked g documentation. Twenty 7 of 30 evening had bet monitoring documentation.  vior charting revealed ccurate charting. One of 31 or monitoring documentation. In monitoring documentation. In monitoring documentation. In monitoring documentation. In monitoring and night shifts lacked ide effect monitoring. Three led documentation for side venty eight of 31 day shifts effect documentation.			
	inconsistent and ina days lacked behavior. Thirty of 30 night and documentation or side day shifts lacked domonitoring and 18 of documentation.  The July 2014 behavior and side effect monitinaccurate side effect documented the plus effects and the leger	avior charting revealed courate charting. Nine of 30 or monitoring documentation. d evening shifts lacked de effect monitoring, 12 of 30 cumentation for side effect f 30 day shifts had inaccurate vior charting revealed courate charting. Two of 13 or monitoring documentation toring. Eleven of 13 days had obt documentation. The staff is sign (+) in the box for side and for potential side effects is were identified with			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE 331 SW OAKLEY TOPEKA, KS 66606	,
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION
F 329	Continued From pa numbers. Thirteen lacked charting for	of 13 night and evening shifts	F 329		
	(MAR) lacked docu 6:00 A.M. on 4/1/14 acceptable blood s				
	revealed the facility movements for the	el charting for April 2014 drailed to monitor bowel resident on 4/20/14, 4/21/14, /24/14, 4/25/14, 4/28/14, 14.			
	blood sugar at 6:00	R lacked documentation of a DA.M. on 5/1/14 and at 4:30 and lacked parameters for ugar levels.			
	revealed the facility movements for the 5/4/14, 5/5/14, 5/6/	el charting for May 2014 failed to monitor bowel resident on 5/1/14, 5/3/14, 14, 5/7/14, 5/8/14, 5/9/14, /12/14, 5/13/14, and 5/14/14.			
		R lacked documentation of a P.M. and lacked parameters d sugar levels.			
	revealed the facility movements for the	el charting for June 2014 failed to monitor bowel resident on 6/10/14, 6/11/14, /20/14, 6/22/14, 6/23/14, 4.			
		atment Administration Record Blacked parameters for ugar levels.			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	(X3) DATE SU	
		17E596	B. WING		07/18/	/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 331 SW OAKLEY TOPEKA, KS 66606	1 3.113	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 329	Continued From pag	e 20	F 32	29		
	sugar monitoring twi Novolin N (insulin) 5 the skin) (SQ) every every evening order The July 2014 POS 100 mg capsules 2 c constipation dated 6 Review of the bowel 10, 2014 revealed th	revealed an order for Colace capsules PO at bedtime for				
	in an activity in the li On 7/14/14 at 4:47 F	P.M. the resident participated ving room. P.M. the resident sat in a chair and talked to him/herself.				
	Interview on 7/14/14 staff Q revealed all 3 they had a bowel mo bowel movement bo a bowel movement f reported it to the nur	at 2:39 P.M. with direct care a shifts asked the residents if every and charted it in the ok. If a resident did not have or a few days he/she se and direct care staff ehaviors to the nurse and				
	nursing staff H reveal bowel charting and value it was complete there were many hole psychotropic medical	at 2:41 P.M. with licensed alled all staff looked at the was responsible for making ad. He/she acknowledged es in the charting and the titions caused constipation.				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		ATE SURVEY OMPLETED
		17E596	B. WING _			07/18/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 331 SW OAKLEY TOPEKA, KS 66606	·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 329	but did not specify w He/she acknowledge	side effects to medications hat side effects they had. ed there were no parameters	F 3	29		
	nursing judgement to	od sugars. He/she used of decide to give the insulin or octor if he/she was not sure.				
	administrative nursing stareffect line of the beherror. He/she stated via observation of th (Abnormal Involunta completed every 6 numbers of there was no daily defined the statement of the stat	ng staff D revealed he/she ff charted (+) on the side avior monitoring document in staff monitored side effects e resident and by the AIMS				
	knew a resident had recorded it and ever nurses monitored the was filled out. He/sh	I monitoring sheet, if day shift a bowel movement they sings filled in the gaps. The at sheet and made sure it e acknowledged some of the ations caused constipation.				
	administrative nursir	ng staff D revealed there rs for blood sugars on the				
	The facility failed to effectiveness of and medications this resi					
	resident #38 dated 6 schizoaffective disor characterized by gro disturbances of lang	sian's Order Sheet (POS) for 5/12/14 revealed diagnoses of der (psychotic disorder less distortion of reality, uage and communication f thought) and anxiety				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E596	B. WING		07/18/2014	
	ROVIDER OR SUPPLIER	1	STREET ADDRESS, CITY, STATE, ZIP CODE  331 SW OAKLEY  TOPEKA, KS 66606		·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 329	irrational fear).  The annual Minimum Assessment Referer revealed the resider Mental Status (BIMS intact) and had no be antipsychotic medical psychosis-any major characterized by a greating), antidepress to treat depression-acterized by exasadness, worthless hypnotic medication sleep) 7 of 7 days of The Care Area Assepsychotropic drug us resident had chronic he/she received psy. He/she needed monof these medications the side effects of the Interventions that prodepression, anxiety, sleep) would be wat The quarterly MDS 3 revealed the resider had no behaviors. Tantipsychotic medical (medication to treat reaction characterize uncertainty and irrational products and irrational medical interventions.	emotional reaction brehension, uncertainty and an Data Set (MDS) 3.0 with an Ince Date (ARD) of 9/13/13 at had a Brief Interview for Si score of 15 (cognitively ehaviors. He/she received ation (medications to treat ar mental disorder ross impairment in reality ant medication (medication abnormal emotional state aggerated feelings of less and emptiness), and (medication that induced at the look back period.  Issment (CAA) for see dated 9/27/13 revealed the emental illness for which chotropic medications. Itoring for the effectiveness and needed monitoring for ese medications. Evented or alleviated his/her and insomnia (inability to ched for and utilized.  In O with an ARD of 6/6/14 at had a BIMS score of 15 and the resident received ation, antianxiety medication anxiety-mental or emotional end by apprehension, ional fear), antidepressant notic medication 7 of 7 days	F 32	9		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		17E596	B. WING _			07/18/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 331 SW OAKLEY TOPEKA, KS 66606	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE . DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 329	Continued From pag	ge 23	F 3	29		
	resident had an alter long history of menta depression and isola administered medical physician, educated medications, information benefits of taking his refused them, monit psychotropic medical and documented at physician of the inefimonitored side effect interactions and information adverse side effects making appropriate consequences of poresident of his/her salencouraged the resident he/she was an					
	resident had an upp and received Levaque medication to thin medication to the face to encouraged proper lead to prevent the spread pack for the face to encourage to congestion, encouraged drinking discouraged exposulungs as needed for breath or audible whomonitored the resident	ed 7/6/14 revealed the er respiratory infection (URI) uin (an antibiotic), Mucinex (a ucous), and Duoneb s (an inhaled medication to s needed (PRN). Staff hand washing and covering of esident coughed and sneezed d of URI, offered a warm treat symptoms of nasal aged adequate hydration, a warm beverages, re to cold dry air, auscultated complaints of shortness of lieezes, recorded any findings, ent's temperature every shift lowing antibiotic therapy and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING _	(X3) DATE SURVEY COMPLETED			
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	ROVIDER OR SUPPLIER		3	STREET ADDRESS, CITY, STATE, ZIP CODE 131 SW OAKLEY TOPEKA, KS 66606		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 329	recorded this, moni of the antibiotic and sounds every shift.  The July 2014 POS orders for Mucinex (PO) twice a day for Levaquin 750 mg Pd dated 7/7/14, and Enebulizer every 4 horders in the resident felt like his/her own fluids. So the resident to the example of the hospital admitted (inflammation of the Anurse's note on 7 the hospital admitted (inflammation of the with levaquin, and with levaquin a	tored for adverse side effects monitored and recorded lung arevealed the resident had 400 milligrams (mg) by mouth 10 days dated 7/4/14, O daily for a URI for 7 days buoneb 3 milliliters (ml) by burs PRN dated 7/6/14.  13 7/4/14 at 9:00 A.M. revealed he/she was drowning in Staff obtained an order to send emergency room.  14/14 at 11:00 A.M. revealed defended the facility, was treated would continue treatment for 7 acked documentation of the ure and lung sounds on the 1/10/14 at 7:30 A.M. revealed facility to go on an overnight acked documentation of the ure and lung sounds.  1/11/14 at 7:30 P.M. revealed do to the facility.	F 329			

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		17E596	B. WING		07/18/2014	
	ROVIDER OR SUPPLIER  N PLACE WEST		331	REET ADDRESS, CITY, STATE, ZIP CODE SW OAKLEY PEKA, KS 66606		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 329	condition.  The July 2014 POS (an medication to treat a day for anxiety da medication to treat a day for anxiety or antipsychotic medication given to tablets PO at bedtin Ambien (a medicat daily for better slee (an antipsychotic mordered 4/21/14, Oday PRN for anxiet Sustenna (an antipsychota)	sounds, or respiratory  The sounds of the series	F 329			
	documentation of s day shifts and 30 o and had inaccurate documentation 26 o  The May 2014 beh documentation 1 of effect monitoring 2 evening and night s effect monitoring do  The June behavior documentation 10 of evening shifts, lack	avior monitoring forms lacked ide effect monitoring 4 of 30 f 30 evening and night shifts, a side effect monitoring of 30 days.  avior monitoring forms lacked f 31 day shifts, lacked side of 31 day shifts and 31 of 31 shifts, and had inaccurate side ocumentation 29 of 31 days.  monitoring forms lacked of 30 day shifts and 1 of 30 led side effect monitoring for and 30 of 30 evening and night				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPL AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		17E596	B. WING		07/	18/2014
	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE 331 SW OAKLEY TOPEKA, KS 66606		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 329	documentation 5 of 3 The July 2014 behard documentation 2 of monitoring for 2 of 1 and nights, and 8 of effect monitoring. T sign (+) in the box for potential side effect were identified with a series were identified	curate side effect monitoring 30 days.  vior monitoring forms lacked 13 days, lacked side effect 3 days and 11 of 13 evenings 13 days had inaccurate side the staff documented the plus or side effects and the legend ects indicated side effects numbers.  charting documents for April acility failed to monitor bowel esident on 4/20/14, 4/21/14, 24/14, 4/25/14, 4/28/14, 4.  charting documents for May acility failed to monitor bowel esident on 5/1/14, 5/3/14, 4, 5/7/14, 5/8/14, 12/14, 5/13/14, and 5/14/14.  charting documents for June acility failed to monitor bowel esident on 6/10/14, 6/11/14, 20/14, 6/22/14, 6/23/14,	F 329			
		A.M. the resident prepared to				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE  331 SW OAKLEY  TOPEKA, KS 66606		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION	
F 329	Interview on 7/14/14 Q revealed all 3 shift had a bowel movement have a bowel movem reported it to the nur reported observed by they charted this.  Interview on 7/14/14 nursing staff H reveat bowel charting and ware it was completed there were many hold psychotropic medical Licensed nursing staff (+) if a resident had about did not specify was little from 7/15/14 nursing staff H reveat antibiotic from 7/7/14 acknowledged there of the residents lung resident returned from 7/11/14.  Interview on 7/15/14 administrative nursing believed nursing staff effect line of the beh error. He/she stated via observation of the (Abnormal Involunta completed every 6 mathere was no daily defined the sound in the stated was no daily defined the sound in the stated was no daily defined the sound in the stated was no daily defined the sound in the stated was no daily defined the sound in the stated was no daily defined the sound in the stated was no daily defined the sound in the stated was no daily defined the sound in the stated was no daily defined the sound in the stated was no daily defined the sound in the stated was no daily defined the sound in the stated was no daily defined the sound in the stated was no daily defined the sound in the stated was no daily defined the sound in the stated was no daily defined the sound in the stated was no daily defined the sound in the stated was no daily defined the sound in the stated was no daily defined the sound in the stated was not defined the stated was not defined the sound in the stated was not defined the stated was no	at 2:39 P.M. direct care staff is asked the residents if they ent and this was charted in a book. If a resident did not ment for a few days he/she is and direct care staff Quehaviors to the nurse and at 2:41 P.M. with licensed alled all staff looked at the was responsible for making did. He/she acknowledged es in the charting and the tions caused constipation. If H reported he/she charted aside effects to medications that side effects they had.  at 8:41 A.M. with licensed alled resident #38 received and and finished 7/13/14 and was no continued monitoring is or temperature after the minis/her overnight pass on at 9:39 A.M. with g staff D revealed he/she of charted (+) on the side avior monitoring document in side effects were monitored to resident and by the AIMS	F 32	9		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 329	knew a resident had recorded it and even the nurses monitored was filled out. He/sh antipsychotic medica and expected staff to care planned for their	I monitoring sheet, if day shift a bowel movement they sings filled in the gaps, and d that sheet and made sure it e acknowledged some of the ations caused constipation o monitor all medications as ir effectiveness.	F 3.	29			
	(MDS) assessment of resident was unable for Mental Status who cognition was impair resident required lim of daily living such as use and personal hy anti-psychotic (media (psychosis) anti-anxi alleviate stress) and used to alleviate feel.  The annual 6/13/14 (CAA) for Mood state schizoid-affective discharacterized by grodisturbances of languand fragmentation of the state of the s	ation used for mental illness iety, (mediation used to anti-depressant (mediation					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E596	B. WING		07/18/2014	
	ROVIDER OR SUPPLIER  N PLACE WEST		3	STREET ADDRESS, CITY, STATE, ZIP CODE 331 SW OAKLEY TOPEKA, KS 66606		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 329	medications for effective unwanted side effective with a side effective anti-depressant memiratzapine; the anti-depressant in a side of the anti-depth in a side of the	ses and required staff to monitor ectiveness as well as potential cts.  2014 Physician's Order Sheet nt received the edications: buspiron, ti-psychotic medications ridone, risperdal, risperdal, and the anti-anxiety am.  comps Drug Reference tion, all the residents eations had a potential of n as a side effect.  thly bowel monitoring logs bugh July 2014 provided by the ff failed to consistently monitor	F 329	, , , , , , , , , , , , , , , , , , ,		
	documented the remedications, however monitor the resident On 7/15/14 at 3:50	plan dated 7/10/14 sident's use of psychotropic ver lacked documentation to t bowel movements.  P.M. the resident sat in his/her the bed arranging his/her				

PRINTED: 07/18/2014 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E596	B. WING			07/	18/2014
	ROVIDER OR SUPPLIER			331	REET ADDRESS, CITY, STATE, ZIP CODE I SW OAKLEY PPEKA, KS 66606		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 329	medications he/she to constipation. The restroutinely ask if he/she had any problem with On 7/10/14 at 8:30 A. nursing staff D acknomonitor residents' bor consistent basis.  The facility did not promonitoring residents and the facility failed to meffects related to bow resident who received.  The quarterly Minim dated 6/6/14 for resident to the facility for Mental Signor cognitive impairmed delusions (untrue per facility as the facility failed to meffects related to bow resident who received.	e was aware of some of the book for depression and sident stated staff did not a had a bowel movement or his/her bowels.  M. administrative licensed wledged staff did not wel movements on a bovide a policy related to bowel movements.  Inonitor for the potential side wel movements for this dipsychotropic medications.  The potential side well movements for this dipsychotropic medications.  The potential side well movements for this dipsychotropic medications.  The potential side well movements for this dipsychotropic medications.  The potential side well movements for this dipsychotropic medications.	F	329			
	directed towards other staff set up for bathing supervision for eating He/she received 7 do medication (medication psychosis; any major characterized by a gritesting), 7 doses of all (a medication used for depression; abnormal characterized by exact sadness, worthlessness	and personal hygiene. ses of an antipsychotic on used for the treatment of mental disorder oss impairment in reality n antidepressant medication or the treatment of I emotional state					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E596	B. WING _			07/	/18/2014
	ROVIDER OR SUPPLIER  N PLACE WEST	,		331 SW	ADDRESS, CITY, STATE, ZIP CODE  OAKLEY  A, KS 66606	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE.	(X5) COMPLETION DATE
F 329	promote the formatio during the 7 day look  The 10/11/13 Care Alpsychotropic drug us received psychotropic monitoring for effective eliminating agitation, mood. Staff also moreffects.  The care plan with a revealed the resident superficial self harm, own faults, attention staff and peers. The resident received psypotential side effects in mood and behavion the physician as need regarding bowel movas needed medication resident reported no  The physician's order revealed the following dates: 11/23/09 Abilification is 11/23/09 antidepressant medic (medication used for Seroquel (an antipsychamitiza (medication used for Seroquel (an antipsychamitiza (medication); 11/23/09 Amitiza (medication); 11/23/09 Amitiz	n and excretion of urine) back period.  rea Assessment (CAA) for e revealed the resident c medications which required veness of controlling or psychosis, and regulating intored for potential side  revision date of 5/21/14 c had behaviors that included inability to recognize his/her seeking, and manipulation of care plan also revealed the vchotropic medications with c Staff monitored for changes rs and reported changes to ded. Staff inquired daily ements (BM) and provided in per standing orders if the BMs for 3 consecutive days.  r sheet signed on 6/12/14 g medications and start by (an antipsychotic c Trazadone (an cation); 11/23/09 Lamictal mood stabilization); 4/22/11 chotic medication); 11/15/11 used for the treatment of v passing stools); 10/31/13 edication used for the	F	329			
		behaviors for Abilify and					

OLIVILIY	OT OIL MEDIO/ IILE &	WEDIO/ ND OLIVIOLO				OIVID IVE	7. 0000 000 1
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E596	B. WING			07/	18/2014
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIGHTO	N PLACE WEST				31 SW OAKLEY OPEKA, KS 66606		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 329	attention seeking; inabehaviors and pointe derogatory name call superficial self harm; Documentation on the failed to follow the dir for proper use. The dependence of the intervention code effects code with initiative for list of behavior C = continuous; D = continuous;	staff due to redirection; ability to recognize own d out faults of others; ing of peers and staff; and poor insight. e form revealed the staff rections printed on the form irections read, "Enter target be behavior sections. Record les by shift with initials. Enter , outcome code, and side als for each shift. See side als for each shift. See side and potential side effects. day; E = evening; N = stently documented for side effects and when used a plus sign instead of the form's directions. Also, was inconsistently even when the interventions cation was used. The staff itoring for the resident's od stabilization. The staff a specific targeted behavior or medication class to be	F	329			
	5/4/14, 5/5/14, 5/6/14 5/10/14, 5/11/14, 5/12 (duration of 12 days)	tion of 4 days), 5/3/14, 1, 5/7/14, 5/8/14, 5/9/14, 2/14, 5/13/14, and 5/14/14 1, 6/22/14, 6/23/14, 6/24/14, 2) of 4 days) without a bowel					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  NG	(X	3) DATE SURVEY COMPLETED
		17E596	B. WING _			07/18/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 331 SW OAKLEY TOPEKA, KS 66606	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 329	resident sat in a charactively participating.  Interview on 7/14/14 staff R revealed the monitoring document residents if they had were independent. It assistance for toiletine ever staff assisted the it on the BM log. Stamembers were confit was to complete the stated staff should do Interview on 7/14/14 nursing staff H reveas sheets were develops staff. Staff H reporte side effect monitoring resident receiving some dications which a side effects. He/she wrote in intervention scheduled medication one to one care and shift. He/she acknow behaviors were not smedication class and effectiveness of each Staff H expected staff.	w/14 at 4:08 P.M. revealed the ir at a dining room table in a group craft activity.  • at 4:04 P.M. with direct care evening shift completed BM station. Staff asked the a BM that day since most if the resident required ing and had a BM then which he resident, would document iff R reported many staff used of whose responsibility it BM documentation. Staff R ocument on the BM log daily.  • at 4:22 P.M. with licensed alled behavior monitoring bed by all licensed nursing d he/she always documented g with a plus sign due to the cheduled psychotropic always had the potential for also stated he/she always s since the resident received ons and staff always provided redirection throughout the wledged the targeted specific to each medication or d therefore the monitoring for h medication was difficult. Iff to complete BM monitoring ged there were multiple gaps in.	F3	329		
	administrative nursir	ng staff D revealed the facility				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		17E596	B. WING			7/18/2014
	ROVIDER OR SUPPLIER  N PLACE WEST			STREET ADDRESS, CITY, STATE, ZIP ( 331 SW OAKLEY TOPEKA, KS 66606		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 329	behavior monitorin nursing staff were forms. Staff D ack of plus signs for si reported he/she be confused on which the staff monitored Abnormal Involunt and observation. So months but did right side effects. Staff BM monitoring do afternoon shift. He knew a resident had document it and the gaps. Staff D experper the care plan a effectiveness of all The 3/09 policy provide a quantitation behavior problems of the intervention.  The June 2013 poregarding bowel as revealed the facility in conjunction with each resident's att.  The facility failed to effectiveness of all and failed to consimovements for this reported to the staff of the st	regarding proper use of the ag forms. Staff D stated the to follow the directions on the nowledged the documentation de effects monitoring and elieved staff were getting a line to document. Staff D said a for side effects through the ary Movement Scale (AIMS) Staff completed the AIMS every not complete daily charting for D expected staff to complete cumentation daily by the extend a BM then they would be evening shift then filled in the extend monitor for the I medications.  Sovided by the facility regarding toring forms for antipsychotic led the forms were used to tive, graphic method of charting as, interventions, and outcomes and bladder management by established a bowel regimen of their medical director and/or ending physician.	F	329		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	_	X3) DATE SURVEY COMPLETED
		17E596	B. WING			07/18/2014
	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, 331 SW OAKLEY TOPEKA, KS 66606	STATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From pa	nge 35	F:	329		
	dated 6/6/14 for resident was always bowel. The resident was always bowel. The resident antipsychotic medication (a medication (a medication) and consider that the first and set up assistar required staff set up resident was always bowel. The resident antipsychotic medication (a medication (a medication) and consider that the first and the first and set up assistar required staff set up resident was always bowel. The resident antipsychotic medication (a medication) and depression—abnowed consideration (a medication) and the disconsideration of reality, communication and depression (absorber of the first and depression) (absorber of the first and the first and depression) (absorber of the first and t	nimum Data Set 3.0 (MDS) sident #34 revealed a Brief al Status score of 12, indicating impairment. He/she tions (sensing things while ed to be real, but the mind ions (untrue persistent belief or a person although evidence ue). The resident was ed mobility, transfer, walking in ing in the corridor, locomotion comotion off the unit. He/she evision for dressing, eating, she required staff supervision for personal hygiene and prassistance for bathing. The is continent of bladder and it received 7 doses of an eation (medication used for the exist-any major mental existed by a gross impairment in 17 doses of an antidepressant cation used for the treatment cormal emotional state (aggerated feelings of the eagnoses of schizophrenia characterized by gross disturbances of language and difragmentation of thought) chormal emotional state (aggerated feelings of thought)				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		17E596	B. WING	<del> </del>		7/18/2014
	ROVIDER OR SUPPLIER  N PLACE WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 331 SW OAKLEY TOPEKA, KS 66606		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 329	Continued From pag	ge 36	F 32	29		
	required psychotrophis/her symptoms to levels. The resident therapeutic effects at the care plan with a revealed the resident behaviors: hallucina threatening aggress internal stimuli. The of psychotropic mediagnoses. He/she black box warning vadverse effects. Stamovements (BMs) of	ness and emptiness) and bic medications to control to tolerable and manageable required staff to monitor for and for adverse side effects.  The revision date of 5/26/14 and displayed the following attions and delusions and sive behaviors related to resident received daily doses dications related to his/her received medications with a which required monitoring for aff assessed for bowel daily and provided as needed inding orders if the resident insecutive days.				
	revealed the following dates: 10/23/09 Prismedication); 10/23/09 for mood stabilization antianxiety medication characterizuncertainty and irrat (an antipsychotic manual (a					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(>	(X3) DATE SURVEY COMPLETED	
		17E596	B. WING			07/18/2014
	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP C 331 SW OAKLEY TOPEKA, KS 66606	ODE	01/10/2014
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 329	delusions for Geodo Documentation on the failed to follow the conformation for proper use. The behavior in one of the the number of episot the intervention code effects code with initive for list of behavior. The continuous; Denights." Staff inconsimonitoring for side at times used a plus listed per the form's section was inconsiceven when the intermedication was use monitoring for the remodestabilization pasheet. The staff also targeted behavior with medication class to effectiveness of each Review of the BM mithrough July 2014 prevealed staff failed The following dates 4/20/14, 4/21/14, 4/4/25/14 (duration of 4/30/14, 5/5/14, 5/6/15/10/14, 5/5/14, 5/6/15/10/14, 5/5/14 (duration of 12 days and 6/25/14 (duration of 7/14 Observation on 7/14	in, and a targeted behavior of on and Clozaril. The form revealed the staff directions printed on the form directions read, "Enter target the behavior sections. Record odes by shift with initials. Enter the physician side effects. The equation of the code and side tials for each shift. See side directions and potential side effects. The equation of the codes of the c	F	329		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E596	B. WING		07/18/2014	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 331 SW OAKLEY TOPEKA, KS 66606	·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	D BE COMPLETION	
F 329	Interview on 7/14/14 staff R revealed the monitoring document residents if they had were independent. It assistance for toiletine ever staff assisted throom the BM log. Staff members were confit was to complete the stated staff should do a linterview on 7/14/14 nursing staff H reveasheets were develops staff. Staff H reporte side effect monitoring resident received somedications which a side effects. He/she wrote in intervention scheduled medication one to one care and shift. He/she acknow behaviors were not smedication class and effectiveness of each difficult. Staff H experimental multiple gaps in BM.  Interview on 7/15/14 administrative nursing held an inservice registed to the staff were to behavior monitoring nursing staff were to the staff of the staff in	at 4:04 P.M. with direct care evening shift completed BM tation. Staff asked the a BM that day since most the resident required and had a BM then which he resident would document it R reported many staff used of whose responsibility it BM documentation. Staff R ocument on the BM log daily.  at 4:22 P.M. with licensed held behavior monitoring held by all licensed nursing domain the licensed held held psychotropic livent a plus sign due to the heduled psychotropic livent had the potential for also stated he/she always so since the resident received has and staff always provided redirection throughout the viedged the targeted specific to each medication or distribution that the product of the medication would be exted staff to complete BM acknowledged there were documentation.	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		17E596	B. WING		07/18/2014	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 331 SW OAKLEY TOPEKA, KS 66606	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION	
F 329	reported he/she beliamessed up on which said the staff monitor the Abnormal Involur (AIMS) and observat AIMS every 6 month charting for side effecomplete BM monitor the afternoon shift. In knew a resident had document it and the gaps. Staff D expect per the care plan and effectiveness of all monitor medications revealed provide a quantitative behavior problems, if of the intervention.	effect monitoring and eved staff were getting line to document on. Staff D red for side effects through narry Movement Scale ion. Staff completed the so but did not complete daily cts. Staff expected staff to ring documentation daily by le/she stated if the day shift a BM then they would evening shift then filled in the ed the nurses to provide care domaitor for the nedications.  Ided by the facility regarding ing forms for antipsychotic dother to the forms were used to expend to e	F 32			
F 371 SS=F	regarding bowel and revealed the facility of in conjunction with the each resident's attention. The facility failed to deffectiveness of the pailed to consistently for this moderately consistently con	consistently monitor the osychotropic medications and monitor bowel movements ognitively impaired resident e psychotropic medications constipation.	F 37	1		

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE COMP	SURVEY LETED
		17E596	B. WING		<del></del>	07/	18/2014
	ROVIDER OR SUPPLIER		•	33	REET ADDRESS, CITY, STATE, ZIP CODE 11 SW OAKLEY DPEKA, KS 66606		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 371	considered satisfacto authorities; and (2) Store, prepare, dis under sanitary conditions.  This REQUIREMENT by: The facility identified with 1 main kitchen.	sources approved or ry by Federal, State or local stribute and serve food ions  is not met as evidenced a census of 48 residents Based on observation and	F:	371			
	distribute, and serve to conditions for 1 of 4 conditions included:	lays on site of the survey.					
	cookie sheets full of p	/14 at 8:52 A.M. revealed 2 partially thawed chicken at room temperature.					
	he/she was getting re						
	staff thawed food by	M. dietary staff EE revealed setting it under running cold ally thawed, he/she let it sit n temperature.					
	On 7/14/14 at 4:33 P.	M. administrative nursing					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		17E596	B. WING			07/18/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 331 SW OAKLEY TOPEKA, KS 66606		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 428 SS=E	refrigerator, not at room The policy for thawing provided by the facility recommended method refrigeration. Other as part of the cooking proor in a microwave.  The facility failed to propose a way that prevented risk of food borne illn 483.60(c) DRUG REGIRREGULAR, ACT CONTROLLER TO The drug regimen of reviewed at least one pharmacist.  The pharmacist must the attending physicial	should thaw foods in the om temperature.  g foods revised March 2009 by revealed the od of thawing food was under acceptable methods were as rocess, under portable water, arepare food for residents in reduced, or eliminated the ess.  GIMEN REVIEW, REPORT	F 33			
	by: The facility identified The sample included observation, record re facility's consultant pl the facility's lack of ce and inconsistent and side effect monitoring	a census of 48 residents.  11 residents. Based on eview, and interview, the narmacist failed to identify onsistent bowel monitoring inaccurate behavior and of for 5 of 5 residents esary medications (#6, #25,				

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		(X3) DATE SURVEY COMPLETED	
	17E596	B. WING		07/18/2014	
	1	STREET ADDRESS, CITY, STATE, ZIP CODE  331 SW OAKLEY  TOPEKA, KS 66606		·	
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
#28, #34, and #38), lack of parameters for 5 residents reviewed medications (#6).  Findings included:  The signed Physic resident #6 dated 6/schizophrenia (psyc by gross distortion or language and commof thought), constipastools), depression (characterized by exasadness, worthless diabetes mellitus (will glucose, not enough cannot respond to the The annual Minimum Assessment Reference (moderate cognitive hallucinations (sensiappear to be real, but delusions (untrue pended by a person althed was untrue), did not behaviors, received antipsychotic (medication for treat reaction characterized uncertainty and irrat (medication for the emotional state characteristics).	and failed to recognize the or blood sugar levels for 1 of a for unnecessary  sian's Order Sheet (POS) for 12/14 revealed diagnoses of notic disorder characterized a freality, disturbances of unication and fragmentation tion (difficulty passing abnormal emotional state aggerated feelings of ess and emptiness), and nen the body cannot use insulin made or the body are insulin).  In Data Set (MDS) 3.0 with an nece Date (ARD) of 3/28/14 at had a BIMS score of 9 impairment). He/she had ng things while awake that at the mind created) and resistent belief or perception nough evidence showed it exhibit verbal or physical injections, insulin, action for the treatment of any er characterized by a gross testing), antianxiety ment of mental or emotional ed by apprehension, ional fear)and antidepressant treatment of abnormal acterized by exaggerated	F 428			
	ROVIDER OR SUPPLIER  SUMMARY S (EACH DEFICIENC REGULATORY OR  Continued From page #28, #34, and #38), lack of parameters for 5 residents reviewed medications (#6).  Findings included:  - The signed Physic resident #6 dated 6/s schizophrenia (psychology gross distortion or language and common of thought), constipates stools), depression (characterized by exastaness, worthlessed diabetes mellitus (wind glucose, not enough cannot respond to the The annual Minimum Assessment Reference revealed the resident (moderate cognitive hallucinations (sensita appear to be real, but delusions (untrue per held by a person althe was untrue), did not behaviors, received antipsychotic (medication for treatment in reality (medication for treatment in reality (medication for the femotional state characterized in the state of the motional state charactering of sadness,	TOUR PLACE WEST  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 42 #28, #34, and #38), and failed to recognize the lack of parameters for blood sugar levels for 1 of 5 residents reviewed for unnecessary medications (#6).	ROVIDER OR SUPPLIER  N PLACE WEST  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 42  #28, #34, and #38), and failed to recognize the lack of parameters for blood sugar levels for 1 of 5 residents reviewed for unnecessary medications (#6).  Findings included:  - The signed Physician's Order Sheet (POS) for resident #6 dated 6/12/14 revealed diagnoses of schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), constipation (difficulty passing stools), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin).  The annual Minimum Data Set (MDS) 3.0 with an Assessment Reference Date (ARD) of 3/28/14 revealed the resident had a BIMS score of 9 (moderate cognitive impairment). He/she had hallucinations (sensing things while awake that appear to be real, but the mind created) and delusions (untrue persistent belief or perception held by a person although evidence showed it was untrue), did not exhibit verbal or physical behaviors, received injections, insulin, antipsychotic (medication for the treatment of any major mental disorder characterized by a gross impairment in reality testing), antianxiety (medication for treatment of mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) and antidepressant (medication for the treatment of abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and	ROVIDER OR SUPPLIER  N PLACE WEST  SUMMARY STATEMENT OF DEFICIENCIES  (REACH DEFICIENCY MUST BE PRECEDED BY SULL (REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 42  #28, #34, and #39), and failed to recognize the lack of parameters for blood sugar levels for 1 of 5 residents reviewed for unnecessary medications (#6).  Findings included:  - The signed Physician's Order Sheet (POS) for resident #6 dated 6/12/14 revealed diagnoses of schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), constipation (difficulty passing stools), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin).  The annual Minimum Data Set ((MDS) 3.0 with an Assessment Reference Date (ARD) of 3/28/14 revealed the resident had a BIMS score of 9 (moderate cognitive impairment). He/she had hallucinations (sensing things while awake that appear to be real, but the mind created) and delusions (untrue persistent belief or perception held by a person although evidence showed it was untrue), did not exhibit verbal or physical behaviors, received injections, insulin, antipsychotic (medication for the treatment of any major mental disorder characterized by a gross impairment in reality testing), antianxiety (medication for treatment of mental or emotional reaction characterized by apprehension, uncertainty and irraility testing), antianxiety (medication for the treatment of abnormal emotional state characterized by exaggerated feelings of Sadness, worthlessness and	

AND DUAN OF CORDECTION INDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION  G	· /	(X3) DATE SURVEY COMPLETED	
		17E596	B. WING	<del> </del>		7/18/2014
	ROVIDER OR SUPPLIER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 331 SW OAKLEY TOPEKA, KS 66606		•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 428	resident had a long is starting at age 16 and medications to contribute as depression as behaviors these cause monitoring for the efficient medications as well the medications as well the medications.  The care plan update resident received day medications that had constipation. Nursing (a stool softner) per blood glucose levels provided dietary fiber for signs and symptosugar, and checked any signs and symptosugar were present.  The July 2014 POS antipsychotic medication (PO) every mordered 7/25/10, Zol medication) 100 mg depression ordered antipsychotic medication ordered 1/26/13, Clomedication) 1 mg PO schizophrenia ordered (an antipsychotic medication) 1 mg PO schizophrenia ordered (an antipsychotic medication) medication ordered (an antipsychotic medication) medication ordered (an antipsychotic medication) medication ordered (an antipsychotic medication) and possible provides and provides antipsychotic medication ordered (an antipsychotic medication) antipsychoti	essment (CAA) for se dated 4/9/14 revealed the history of mental illness di required psychotropic ol symptoms of the illness and psychosis as well as sed. He/she needed fectiveness of the as for adverse side effects of ed 7/4/14 revealed the illy doses of psychotropic di the potential for g staff administered Colace physician's orders, monitored per physician's orders, ras needed, staff monitored oms of high and low blood the resident's blood sugar if toms of high or low blood enversed or so high or low blood enversed of the potential for g staff administered colors of high and low blood the resident's blood sugar if toms of high or low blood enversed or schizophrenia of (an antidepressant 2 tablets PO daily for 8/27/08, Clozapine (an antion) 100 mg PO twice a day dered 1/26/13, Clozapine 100 red imazepam (an antianxiety of twice a day for ed 1/26/13, and Haloperidol edication) 5 mg PO three ed (PRN) for agitation and	F 42	28		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		17E596	B. WING		07/18/2014
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  331 SW OAKLEY  TOPEKA, KS 66606		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 428	Continued From pag	ge 44	F 428		
	inconsistent and ina day shifts and 1 of 3 behavior monitoring night and evening sl monitoring documer lacked side effect m Twenty four of 30 dainaccurate side effect. The May 2014 beha inconsistent and ina day shifts lacked be documentation. Thir night shifts lacked dimonitoring. Three of documentation for seight of 31 days had documentation.  The June 2014 beha inconsistent and ina days lacked behavior. Thirty of 30 night and documentation for seight of 31 days had documentation for seight of 30 night and documentation for seight of 30 night and documentation.  The July 2014 beha inconsistent and ina days lacked behavior and side effect monitinaccurate side effect documented the plue effects and the leger	evior charting revealed accurate charting. Nine of 30 to evening shifts lacked documentation. Thirty of 30 to evening shifts lacked side effect to evior charting revealed accurate charting. One of 31 to evening and ocumentation for side effect effect monitoring documentation. The staff is sign (+) in the box for side effects of 13 days had be effect of 13 days had be evening shifts lacked in evening evening. Twenty is inaccurate side effect evening shift lacked in evening shift lac			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		17E596	B. WING		07	/18/2014
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 331 SW OAKLEY TOPEKA, KS 66606		E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL : LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 428	Iacked charting for some control of the powel revealed the facility of the bowel revealed the facility of the May 2014 MAR blood sugar at 6:00 pp.M. on 5/31/14, and acceptable blood sugar at 6:00 pp.M. on 5/31/14, and acceptable blood sugar at 6:00 pp.M. on 5/31/14, and acceptable blood sugar at 6:00 pp.M. on 5/31/14, and acceptable blood sugar at 6:00 pp.M. on 5/31/14, 5/5/14, 5/5/14, 5/5/14, 5/5/14, 5/5/14, 5/5/14, 5/5/14, 5/5/14, 5/10/14, 5/11/14, 5/11/14, 5/11/14, 5/11/14, 5/11/14, 5/11/14, 5/11/14, 5/11/14, 5/11/14, 5/11/14, 5/11/14, 5/11/14, 5/11/14, 5/11/14, 5/11/14, 5/11/14, 5/11/14, 5/11/14, 5/11/14, 6/11/14, 6/11/14, 6/11/14, 6/11/14, 6/11/14, 6/11/14, 6/11/14, 6/11/14, and 6/25/14/14, and 6/25/14/14	f 13 night and evening shifts ide effects.  cation Record Review (MAR) on of a blood sugar at 6:00 acked parameters for gar levels.  charting for April 2014 failed to monitor bowel esident on 4/20/14, 4/21/14, 24/14, 4/25/14, 4/28/14, 4.  lacked documentation of a A.M. on 5/1/14 and at 4:30 d lacked parameters for gar levels.  charting for May 2014 failed to monitor bowel esident on 5/1/14, 5/3/14, 4, 5/7/14, 5/8/14, 5/9/14, 2/14, 5/13/14, and 5/14/14.  R lacked documentation of a P.M. and lacked parameters sugar levels.  charting for June 2014 failed to monitor bowel esident on 6/10/14, 6/11/14, 20/14, 6/22/14, 6/23/14, 4.	F 428	В		
		ment Administration Record lacked parameters for gar levels.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		17E596	B. WING		07/18/2014	
	ROVIDER OR SUPPLIER	•	STREET ADDRESS, CITY, STATE, ZIP CODE  331 SW OAKLEY  TOPEKA, KS 66606			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION	
F 428	sugar monitoring twi Novolin N (insulin) 5 the skin) (SQ) every evening order  The July 2014 POS 100 mg capsules 2 constipation dated 6 Review of the bowel 1 daily through July failed to monitor bow resident on 7/9/14 a  The consultant phar regimen reviews on 3/5/14, 2/12/14, 1/8/9/4/13, 8/7/13, 7/3/1 June, May and April lacked documentatic recognized the facility effect, and bowel more parameters for this recognized the facility of the light of the light of the facility of the light of the ligh	revealed and order for blood ce a day dated 9/23/08 and units subcutaneous (beneath morning and 3 units SQ ed 6/1/97.  revealed an order for Colace capsules PO at bedtime for /1/97.  charting documents for July 10, 2014 revealed the facility wel movements for the nd 7/10/14.  macist completed drug 7/2/14, 6/4/14, 5/6/14, 4/2/14, 14, 12/4/13, 11/6/13, 10/2/13, 3, and unknown dates in of 2013. The clinical record on the consultant pharmacist by's inadequate behavior, side onitoring, and the lack of esidents blood sugar.  P.M. the resident participated ving room.  P.M. the resident sat in a chair and talked to him/herself.  at 2:41 P.M. with licensed aled the director of nursing macy recommendations.  at 11:29 A.M. administrative	F 428			
		aled he/she expected the to identify and report				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		17E596	B. WING		07/18/2014
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 331 SW OAKLEY TOPEKA, KS 66606		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 428	staff KK revealed he paramenters usually listed. He/she had reparamenters for medical advise staff on behalfect monitoring and psychotropic medical and side effect monitoring.  The 12/15/01 policy regarding the drug regarding the consultant pharmac required per state regimen. If a potentiation be communicated of nursing, the consultant pharmacility's lack of consider the consultant pharmacility's lack of consider the signed Physic resident #38 dated to schizoaffective disorder the signed Physic resident #38 dated to schizoaffective disorder the signed Physic resident #38 dated to schizoaffective disorder the signed Physic resident #38 dated to schizoaffective disorder the signed Physic resident #38 dated to schizoaffective disorder the signed Physic resident #38 dated to schizoaffective disorder the signed Physic resident #38 dated to schizoaffective disorder the signed Physic resident #38 dated to schizoaffective disorder (mental or disorder (mental or disorder (mental or disorder the signed Physic resident #38 dated to schizoaffective disorder (mental or disorder (mental or disorder the signed Physic resident #38 dated to schizoaffective disorder the signed Physic resident #38 dated to schizoaffective disorder the signed Physic resident #38 dated to schizoaffective disorder the signed Physic resident #38 dated to schizoaffective disorder the signed Physic resident #38 dated to schizoaffective disorder the signed Physic resident #38 dated to schizoaffective disorder the signed Physic resident #38 dated to schizoaffective disorder the signed Physic resident #38 dated to schizoaffective the signed Physic resident #38 dated to schizoaffective the signed Physic resident #38 dated to schizoaffective the signed Physic resident #38 dated to schizo	lity.  If at 2:00 P.M. with consultant elshe looked at medication and expected them to be not reviewed the facility's but believed it was reviewed ant pharmacists. He/she did avior and medication side dibelieved all residents on ations should have behavior itoring and consistent bowel provided by the facility egimen review revealed the ist visited the facility as egulation to review the drugial or actual problem needed at to the physician or director ultant pharmacist ingly.  In macist failed to identify the sistent and accurate bowel, effect monitoring and lack of ideations.  In cian's Order Sheet (POS) for 6/12/14 revealed diagnoses of reder (psychotic disorder loss distortion of reality, juage and communication of thought) and anxiety	F 428		

AND PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		17E596	B. WING _			7/18/2014	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 331 SW OAKLEY TOPEKA, KS 66606			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 428	Assessment Reference revealed the resident Mental Status (BIMS intact) and had no be antipsychotic medical psychosis-any major characterized by a gesting), antidepress to treat depression-acharacterized by exasadness, worthless hypnotic medication sleep) 7 of 7 days of The Care Area Assepsychotropic drug us resident had chronic he/she received psyche/she needed mon of these medications the side effects of the Interventions that prodepression, anxiety, sleep) would be water The quarterly MDS 3 revealed the resident had no behaviors. The antipsychotic medical (medication to treat a reaction characterized uncertainty and irrationed medication, and hyp of the look back periods.	n Data Set (MDS) 3.0 with an ince Date (ARD) of 9/13/13 thad a Brief Interview for solve of 15 (cognitively chaviors. He/she received ation (medications to treat mental disorder ross impairment in reality ant medication (medication ibnormal emotional state aggerated feelings of ess and emptiness), and (medication that induced the look back period.  Sesment (CAA) for see dated 9/27/13 revealed the mental illness for which chotropic medications. Sevented or alleviated his/her and insomnia (inability to ched for and utilized.  3.0 with an ARD of 6/6/14 thad a BIMS score of 15 and the resident received ation, antianxiety medication anxiety-mental or emotional and by apprehension, onal fear), antidepressant notic medication 7 of 7 days	F 4	28			
	resident had an alter	viewed 3/10/14 revealed the ed mood state and had a al illness with severe bouts of					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		17E596	B. WING			7/18/2014
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F 428	administered medical physician, educated medications, informe benefits of taking his refused them, monitor psychotropic medical and documented at lephysician of the ineffer monitored side effect interactions and infor adverse side effects, making appropriate of consequences of pooresident of his/her sate encouraged the reside when he/she was another to treat an aday for anxiety of an aday for anxiety of an aday for anxiety or antipsychotic medication to treat and a day for anxiety or antipsychotic medication given to a tablets PO at bedtime Ambien (a medication daily for better sleep (an antipsychotic medication given to a tablets PO at bedtime Ambien (a medication daily for better sleep (an antipsychotic medication given to a tablets PO at bedtime Ambien (a medication daily for better sleep (an antipsychotic medication given to a tablets PO at bedtime Ambien (a medication daily for better sleep (an antipsychotic medication given to a tablets PO at bedtime Ambien (a medication daily for better sleep (an antipsychotic medication given to a tablets PO at bedtime Ambien (a medication daily for better sleep (an antipsychotic medication daily for anxiety sustenna (an antipsychotic medication	ting behavior. Nursing staff tions as ordered by the the resident regarding the d the resident of risks versus //her medications if he/she ored for effectiveness of tions on an ongoing basis east quarterly, informed the ectiveness of medications, s to medications during med the physician of assisted the resident in lecisions, discussed or decisions, reassured the fety in the facility, and lent to utilize coping skills	F 4:	28		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER'SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		17E596	B. WING		07/18/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  331 SW OAKLEY  TOPEKA, KS 66606	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 428	day shifts and 30 of and had inaccurate sidocumentation 26 of  The May 2014 behave documentation 1 of 3 effect monitoring 2 of evening and night shifts, lacke 25 of 30 day shifts a shifts, and had inaccumentation 5 of 3 of 5 the July 2014 behave documentation 2 of 2 effect monitoring for 13 evening and night inaccurate side effect documented the plus documented the plus shifts and had inaccurate side effect documented the plus shifts and had inaccurate side effect documented the plus shifts and had inaccurate side effect documented the plus shifts and had inaccurate side effect documented the plus shifts and had inaccurate side effect documented the plus shifts and had inaccurate side effect documented the plus shifts and shift	le effect monitoring 4 of 30 avening and night shifts, side effect monitoring 30 days.  Vior monitoring forms lacked 31 day shifts, lacked side f 31 day shifts and 31 of 31 lifts, and had inaccurate side cumentation 29 of 31 days.  Inonitoring forms lacked 30 day shifts and 1 of 30 d side effect monitoring for and 30 of 30 evening and night lurate side effect monitoring so days.  Vior monitoring forms lacked 13 day shift, lacked side 2 of 13 day shifts and 11 of a shifts, and 8 of 13 days had at monitoring. The staff as sign (+) in the box for side and for potential side effects	F 42	28	
	2014 revealed the fa	charting documents for April cility failed to monitor bowel esident on 4/20/14, 4/21/14, 4/14, 4/25/14, 4/28/14,			
	2014 revealed the fa movements for the re	charting documents for May cility failed to monitor bowel esident on 5/1/14, 5/3/14, 4, 5/7/14, 5/8/14, 5/9/14,			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		17E596	B. WING	<del></del> -	07/18/2014
	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE 331 SW OAKLEY TOPEKA, KS 66606	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETIO
F 428	Review of the bowel 2014 revealed the farmovements for the right of 6/18/14, 6/19/14, 6/26/24/14, and 6/25/14 Review of the bowel 2014 revealed the farmovements for the right of 7/10/14. Review of the month dated 4/13, 5/13, 6/110/2/13, 11/6/13, 12/4/2/14, 5/6/14, 6/4/12 pharmacy recommen monitoring, medicating effectiveness. On 7/14/14 at 7:33 A On 7/15/14 at 10:15 leave the facility for a completed the pharm on the pharmacy consultant concerns to the facility's behavior model.	charting documents for June acility failed to monitor bowel esident on 6/10/14, 6/11/14, 20/14, 6/22/14, 6/23/14, 4.  charting documents for July acility failed to monitor bowel esident on 7/9/14 and  ally Drug Regimen Reviews 13, 7/3/13, 8/7/13, 9/4/13, 7/3/13, 8/7/14, 4, and 7/2/14 revealed no andations regarding bowel on side effects or  A.M. the resident slept in bed.  A.M. the resident prepared to an appointment with staff.  at 2:41 P.M. with licensed alled the director of nursing macy recommendations.  at 11:29 A.M. administrative alled he/she expected the to identify and report	F 42	28	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE 331 SW OAKLEY TOPEKA, KS 66606	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION	
F 428	residents on psycho have behavior and so consistent bowel modern and so consistent bowel modern and so consistent bowel modern and so consultant pharmaci required per state regimen. If a potentiation be communicated of nursing, the consultant pharmaci facility's lack of consistent pharmaci facility's lack of consistent and side experience.	aff on behavior and ct monitoring and believed all tropic medications should ide effect monitoring and unitoring.  provided by the facility egimen review revealed the st visited the facility as gulation to review the drug all or actual problem needed to the physician or director ultant pharmacist ngly.  macist failed to identify the istent and accurate bowel, affect monitoring.	F 428	В		
	(MDS) assessment of resident was unable for Mental Status wh	nual Minimum Data Set 3.0 dated 5/30/14 recorded the to complete a Brief Interview hich indicated the resident's red. The MDS recorded the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		17E596	B. WING		07/18/2014		
	ROVIDER OR SUPPLIER		3	STREET ADDRESS, CITY, STATE, ZIP CODE 131 SW OAKLEY FOPEKA, KS 66606	,		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION		
F 428	of daily living such a use and personal hy anti-psychotic (med (psychosis) anti-any alleviate stress) and used to alleviate feet.  The annual 6/13/14 (CAA) for Mood stat schizoid-affective di characterized by grd disturbances of lang and fragmentation of emotional reaction) control mood swings medications for effect unwanted side effect Review of the the Ju Sheet (POS) reveal anti-depressant med miratzapine; the antifluphenazin, paliper consta, and Invega, medication lorazepath. According to Lexicol Handbook 12th edit psychotropic medica causing constipation. Review of the month April 2014 through a facility revealed staff the resident's bowel	inited assistance with activities as, mobility, dressing, toilet agiene, and received iation used for mental illness siety, (mediation used to anti-depressant (mediation elings of sadness).  Care Area Assessment as a received, the resident had sorder (a psychotic disorder as distortion of reality, guage and communication and received medications to and required staff to monitor activeness as well as potential and received the dications: buspiron, ii-psychotic medications idone, risperdal, risperdal and the anti-anxiety am.  Tomps Drug Reference and an apotential of an as a side effect.  The bowel monitoring logs from July 2014 provided by the failed to consistently monitor	F 428				
		ements 4/20/14, 4/21/14, 24/14, and 4/25/14 (duration					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		17E596	B. WING		07/18/2014	
	OVIDER OR SUPPLIER PLACE WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 331 SW OAKLEY TOPEKA, KS 66606		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION	
	(duration of 4 days), 5/6/14, 5/7/14, 5/8/14 5/12/14, 5/13/14, and days), 6/22/14, 6/23/ (duration of 4 days) where the resident's care produced the resident of the resident of the produced reside	A/29/14, 4/30/14, and 5/1/14 5/3/14, 5/4/14, 5/5/14, I, 5/9/14, 5/10/14, 5/11/14, If 5/14/14 (duration of 12 14, 6/24/14, and 6/25/14 without a bowel movement.  Alan dated 7/10/14 dent's use of psychotropic er lacked documentation to bowel movements.  Regimen Review for 1/14, 6/14, revealed no pharmacy garding side effect monitoring.  Alan dated 7/10/14 dent's use of psychotropic er lacked documentation to bowel movements.  Regimen Review for 1/14, 6/14, revealed no pharmacy garding side effect monitoring.  Alan the resident sat in his/her he bed arranging his/her he was aware of some of the ook for depression and sident stated staff did not his/her bowels.  Alan administrative licensed byledged staff did not wel movements on a  Alan a telephone interview rmacy consultant KK e expected the facility to	F 42	8		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		17E596	B. WING _			07/18/2014
	ROVIDER OR SUPPLIER  N PLACE WEST			STREET ADDRESS, CITY, STATE, ZIP CODE 331 SW OAKLEY TOPEKA, KS 66606	·	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 428	regimen. If a potent to be communicated of nursing, the considocumented accord. The facility failed to effectiveness and/o to bowel movement received psychotropy.  The quarterly Min dated 6/6/14 for res Interview for Mental no cognitive impairring delusions (untrue public held by a person alt was untrue) and verificated towards off staff set up for bathis supervision for eating He/she received 7 comedication (medication (medication), 7 doses of (a medication used depression; abnorming characterized by existing), 7 doses of (a medication used depression; abnorming the 7 day look. The 10/11/13 Care in psychotropic drug unreceived psychotropic drug	egulation to review the drug dal or actual problem needed do to the physician or director ultant pharmacist ingly.  monitor medication or potential side effects related as for this resident who obic medications.  imum Data Set 3.0 (MDS) dent #28 revealed a Brief Status score of 15, indicating ment. He/she displayed dersistent belief or perception though evidence showed it that behavioral symptoms mers. The resident required mg and required staffing and personal hygiene. Hoses of an antipsychotic tion used for the treatment of the mental disorder gross impairment in reality an antidepressant medication for the treatment of the treatment of the treatment of the displayed dersistent belief or perception hough evidence showed it with the displayed dersistent belief or perception for the resident required staffing and personal hygiene. Hoses of an antipsychotic displayed dersistent displayed dersistent displayed dersistent displayed dersistent displayed dersident displayed der	F 4	28		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		17E596	B. WING _			07/18/2014	
	ROVIDER OR SUPPLIER		,	STREET ADDRESS, CITY, STATE, ZIP COL 331 SW OAKLEY TOPEKA, KS 66606	DE		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CC ( (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 428	Continued From pag	ge 56	F 4	28			
		, psychosis, and regulating initored for potential side					
	revealed the resider superficial self harm own faults, attention staff and peers. The resident received potential side effects in mood and behavithe physician as neergarding bowel moas needed medicatiresident reported no	a revision date of 5/21/14 at had behaviors that included a, inability to recognize his/her a seeking, and manipulation of a care plan also revealed the sychotropic medications with a. Staff monitored for changes ors and reported changes to eded. Staff inquired daily evements (BM) and provided on per standing orders if the b BMs for 3 consecutive days.  er sheet signed on 6/12/14					
	revealed the following dates: 11/23/09 Abil medication); 11/23/0 antidepressant med (medication used fo Seroquel (an antips Amitiza (medication constipation; difficul	ng medications and start ify (an antipsychotic 09 Trazadone (an ication); 11/23/09 Lamictal r mood stabilization); 4/22/11 ychotic medication); 11/15/11 used for the treatment of ty passing stools); 10/31/13 iedication used for the					
	2014 Behavior Mon following targeted b Seroquel: cursed at attention seeking; ir behaviors and point derogatory name casuperficial self harm Documentation on t	e, July 1st through (-) 10th, itoring sheet revealed the ehaviors for Abilify and staff due to redirection; lability to recognize own ed out faults of others; alling of peers and staff; and poor insight.  The form revealed the staff irections printed on the form					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E596	B. WING				07/18/2014	
	N PLACE WEST		•	331 8	EET ADDRESS, CITY, STATE, ZIP CODE SW OAKLEY EKA, KS 66606	<u> </u>	0,,,0,20,,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 428	behavior in one of the number of episot the intervention code effects code with initiative for list of behave C = continuous; D = nights." Staff incons regarding monitorin documented at time the codes listed per the outcome section documented by staff listed showed a me failed to include mo Lamictal used for malso failed to provid with each medication	directions read, "Enter target the behavior sections. Record odes by shift with initials. Enter le, outcome code, and side titals for each shift. See side iors and potential side effects. e day; E = evening; N = sistently documented g for side effects and when as used a plus sign instead of the form's directions. Also,	F	428				
	through July 10,201 revealed staff failed The following dates 4/20/14, 4/21/14, 4/4/25/14 (6 day dura 4/30/14, and 5/1/14 5/4/14, 5/5/14, 5/6/25/10/14, 5/11/14, 5/ (12 day duration), 66/25/14 (4 day duration) movement.  The Drug Regimen consultant pharmace	ne BM monitoring logs from April 2014 y 10,2014 provided by the facility aff failed to consistently monitor BMs. ng dates lacked documentation: 11/14, 4/22/14, 4/23/14, 4/24/14, and day duration), 4/28/14, 4/29/14, d 5/1/14 (4 day duration), 5/3/14, 14, 5/6/14, 5/7/14, 5/8/14, 5/9/14, 1/14, 5/12/14, 5/13/14, and 5/14/14 ation), 6/22/14, 6/23/14, 6/24/14, and day duration) without a bowel egimen Review revealed the obarmacist reviewed the resident's ard on the following dates: 4/3/13,						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDI		ISTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER  N PLACE WEST			STREET ADDRESS, CITY, STATE, ZIP CODE  331 SW OAKLEY  TOPEKA, KS 66606			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 428	5/7/14, 6/4/14, and 7 pharmacist's notes re recognize and report provide consistent be monitoring.  Observation on 7/10/resident sat in a chain actively participating.  Interview on 7/14/14 staff R revealed the emonitoring document residents if they had were independent. If assistance for toiletin ever staff assisted the it on the BM log. Staff members were confluwas to complete the stated staff should do Interview on 7/14/14 nursing staff H revea sheets were develop staff. Staff H reported side effect monitoring resident receiving somedications which all side effects. He/she awrote in interventions scheduled medication one to one care and shift. He/she acknow behaviors were not side effectiveness of each effectiveness effectiveness of each effectiveness	2/14, 2/12/14, 3/5/14, 4/2/14, 2/2/14. Review of the evealed he/she failed to to the facility their failure to chavior and bowel  2/14 at 4:08 P.M. revealed the rat the dining room table in a group craft activity.  2/14 at 4:04 P.M. with direct care evening shift completed BM tation. Staff asked the a BM that day since most the resident required ag and had a BM then which e resident, would document asked of whose responsibility it BM documentation. Staff Rocument on the BM log daily.  2/14 at 4:08 P.M. with direct care evening shift completed BM tation. Staff asked the a BM that day since most the resident required ag and had a BM then which e resident, would document ff R reported many staff used of whose responsibility it BM documentation. Staff Rocument on the BM log daily.  2/14 at 4:08 P.M. with direct care evening shift completed BM tation. Staff asked the about the beduled pendormal for also stated he/she always documented gwith a plus sign due to the heduled psychotropic ways had the potential for also stated he/she always rovided redirection throughout the	F	128			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E596	B. WING _			07	//18/2014
	ROVIDER OR SUPPLIER			STREET ADDRES  331 SW OAKLEY  TOPEKA, KS			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EAC	PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOUL S-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 428	Interview on 7/15/2 administrative nursheld an inservice rebehavior monitorin nursing staff wereforms. Staff D ackrof plus signs for signeported he/she beconfused on which the staff monitored Abnormal Involunts and observation. So months but did niside effects. Staff I BM monitoring docafternoon shift. He knew a resident had document it and the gaps. Staff D expeight per the care plan a effectiveness of all he/she expected the identify and report expected the facility pharmacist KK revitacility staff on behavior in psychotropic medicincluded. He/she dominitoring for model included. He/she dominitoring for model.	edged there were multiple gaps on.  14 at 9:39 A.M. with sing staff D revealed the facility egarding proper use of the g forms. Staff D stated the to follow the directions on the nowledged the documentation de effects monitoring and elieved staff were getting line to document. Staff D said for side effects through the ary Movement Scale (AIMS) staff completed the AIMS every ot complete daily charting for D expected staff to complete sumentation daily by the stated if the day shift at a BM then they would be evening shift then filled in the concerns to the facility. He/she sy staff to follow up on any	F	128			

	DF DEFICIENCIES CORRECTION			· · · ·	(X3) DATE SURVEY COMPLETED	
		17E596	B. WING	<del> </del>		07/18/2014
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 428	regarding the drug re consultant pharmacis required per state regregimen. If a potentia to be communicated of nursing, the consu documented according The consultant pharm report to the facility the monitor the effectiver medications and their monitor bowel mover	provided by the facility gimen review revealed the st visited the facility as gulation to review the drug I or actual problem needed to the physician or director Itant pharmacist ngly.  Inacist failed to recognize and neir failure to consistently ness of all the psychotropic or failure to consistently nents for this resident who chotropic medications and	F 42	28		
	dated 6/6/14 for resident for Mental Standards awake that appeared created); delusions (uperception held by a showed it was untrue independent with bed his/her room, walking on the unit, and locor required staff superviand toilet use. He/she and set up assistance required staff set up a resident was always	ons (sensing things while to be real, but the mind untrue persistent belief or person although evidence				

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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN O  (EACH CORRECTIVE AC  CROSS-REFERENCED TO  DEFICIEN	CTION SHOULD BE THE APPROPRIAT	(X5) COMPLE DATE	TION
F 428	treatment of psychos disorder characterize reality testing), and 7 medication (a medication of depressionabnormaterized by exact sadness, worthlessnet the 7 day look back put the 3/26/14 Care Are psychotropic medicat resident had the diag (psychotic disorder of distortion of reality, discommunication and finand depression (abnormant d	tion (medication used for the is any major mental d by a gross impairment in doses of an antidepressant tion used for the treatment mal emotional state ggerated feelings of ess and emptiness) during eriod.  The Assessment (CAA) for ion use revealed the moses of schizophrenia haracterized by gross sturbances of language and ragmentation of thought) ormal emotional state ggerated feelings of ess and emptiness) and emedications to control colerable and manageable equired staff to monitor for ad for adverse side effects.  The vision date of 5/26/14 displayed the following ons and delusions and rebehaviors related to esident received daily doses cations related to his/her exceived medications with a hich required monitoring for assessed for bowel illy and provided as needed ding orders if the resident	F	128			
	The physician's order	sheet signed 6/12/14					

AND DI AN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULT A. BUILDII	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CO 331 SW OAKLEY TOPEKA, KS 66606	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL : LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	,	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 428	dates: 10/23/09 Pris medication); 10/23/0 for mood stabilizatio antianxiety medication reaction characterize uncertainty and irrati (an antipsychotic medication (an antipsychotic medication (an anticonstipation medication); and anticonstipation medication of the April 2014, May 1-10, 2014 behavior target behavior of the behaviors related to Lorazepam, Clozaril showed a targeted be Clozaril and Geodor delusions for Geodo Documentation on the failed to follow the differ proper use. The debehavior in one of the number of episor the intervention code effects code with initi two for list of behavior in consistency in the form's section was inconsistent was used a plus listed per the form's section was used as unconsistent was used as used as the continuous of the intervention was used as used as the continuous of th	ing medications and start tiq (an antidepressant 19 Lamictal (medication used in); 10/23/09 Lorazepam (an ion mental or emotional ed by apprehension, sonal fear); 10/23/09 Clozaril edication); 6/17/10 Geodon edication); 11/10/11 Docusate estipation medication difficulty 12/1/11 Mirilax (an idication).  2014, June 2014, and July monitoring forms revealed a reatening aggressive internal stimuli for and Geodon. The form also behavior of hallucinations for and a targeted behavior of an and Clozaril. The form revealed the staff in fections printed on the form directions read, "Enter target lee behavior sections. Record des by shift with initials. Enter ite, outcome code and side itals for each shift. See side itals for each shift.	F	428		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER  N PLACE WEST		331	REET ADDRESS, CITY, STATE, ZIP CODE SW OAKLEY PEKA, KS 66606		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE COMPLETION	
F 428	sheet. The staff alstargeted behavior with medication class to effectiveness of each Review of the BM in through July 2014 prevealed staff failed The following dates 4/20/14, 4/21/14, 4/4/25/14, 4/28/14, 4/5/4/14, 5/5/14, 5/6/10/14, 5/11/14, 5/6/10/14, 6/11/14, 6/6/22/14, 6/23/14, 6/23/14, 6/23/14, 6/23/14, 6/23/14, 6/3/11/6/13, 12/4/13, 1/5/6/14, 6/4/14, and pharmacist's notes recognize and repoprovide consistent by monitoring.  Observation on 7/14 resident sat at a tab breakfast, and conversidents if they have eindependent.	per the physician's order of failed to provide a specific with each medication or be able to evaluate the ch medication.  Inonitoring logs from April 2014 provided by the facility of the consistently monitor BMs. Is lacked documentation:  1/22/14, 4/23/14, 4/24/14, 1/29/14, 4/30/14, 5/1/14, 5/3/14, 1/2/14, 5/13/14, 5/13/14, 5/13/14, 5/13/14, 5/13/14, 6/19/14, 6/20/14, 1/24/14, 6/25/14, 7/9/14, and  Review revealed the cist reviewed the resident's be following dates: 4/3/13, 8/13, 8/8/13, 9/4/13, 10/2/13, 8/14, 2/12/14, 3/5/14, 4/2/14, 7/2/14. Review of the revealed he/she failed to rt to the facility their failure to	F 428			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 428	Continued From pa	ge 64	F 4	28		
	on the BM log. Staff members were confi was to complete the stated staff should of the staff. Staff H reverside the staff. Staff H reported side effect monitoring resident receiving somedications which a side effects. He/she wrote in intervention scheduled medication scheduled medication to one care and shift. He/she acknown behaviors were not medication class an effectiveness of each difficult. Staff H expression of the staff should be staff to the staff should be	ne resident would document it R reported many staff fused of whose responsibility it BM documentation. Staff R flocument on the BM log daily.  If at 4:22 P.M. with licensed field behavior monitoring field he/she always documented field he/she always documented field he/she always documented field he/she always fiel				
	held an inservice re behavior monitoring nursing staff were to forms. Staff D ackno of plus signs for side reported he/she bel messed up on which said the staff monitor the Abnormal Involut (AIMS) and observations.					

AND BLAN OF CORRECTION IN INDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		17E596	B. WING		07/18/2014	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE  331 SW OAKLEY  TOPEKA, KS 66606		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
F 428	the afternoon shift. In knows that a resider document it and the gaps. Staff D expect per the care plan and effectiveness of all in he/she expected the identify and report of expected the facility pharmacy recommental interview on 7/16/14 pharmacist KK reveat facility staff on behavior monitoring. Consultate provide behavior monitoring for mood KK expected the stamonitoring.  The 12/15/01 policy regarding the drug reconsultant pharmacis required per state regimen. If a potentia to be communicated of nursing, the consultant endocumented according the drug reconsultant pharmacis required per state regimen. If a potentia to be communicated of nursing, the consultant pharmacid documented according the drug reconsultant pharmacis required per state regimen. If a potentiate documented according the drug reconsultant pharmacia required per state regimen. If a potentiate documented according the drug reconsultant pharmacia required per state regimen. If a potentiate documented according the drug reconsultant pharmacia required per state regimen. If a potentiate documented according the drug regimen according to the drug regimen and the drug regimen according to the	le/she stated if the day shift at had a BM then they would evening shift then filled in the ed the nurses to provide care ad monitor for the nedications. Staff D reported consultant pharmacist to concerns to the facility. He/she staff to follow up on any nodations.  at 2:00 P.M. with consultant aled he/she did advise the vior and side effect ant staff KK expected staff to nitoring to all residents on tions with side effects not expect behavior stabilizers. Consultant staff ff to provide consistent bowel  provided by the facility egimen review revealed the st visited the facility as gulation to review the drug all or actual problem needed to the physician or director ultant pharmacist	F 42	8		
	report to the facility t monitor the effective medications and the monitor bowel move	heir failure to consistently ness of all the psychotropic ir failure to consistently ments for this moderately resident that received				

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
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(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLETION
Continued From pag	ge 66	F 42	28	
medications for cons 483.60(b), (d), (e) D	stipation. RUG RECORDS,	F 43	31	
a licensed pharmaci of records of receipt controlled drugs in s accurate reconciliati records are in order	st who establishes a system and disposition of all ufficient detail to enable an on; and determines that drug and that an account of all			
labeled in accordance professional principle appropriate accessed	ce with currently accepted es, and include the ory and cautionary			
facility must store all locked compartment controls, and permit	drugs and biologicals in s under proper temperature only authorized personnel to			
permanently affixed controlled drugs liste Comprehensive Dru Control Act of 1976 abuse, except when package drug distrib	compartments for storage of ed in Schedule II of the g Abuse Prevention and and other drugs subject to the facility uses single unit oution systems in which the			
	ROVIDER OR SUPPLIER  SUMMARY S (EACH DEFICIENT REGULATORY OF SUPPLIER OF SUMMARY S (EACH DEFICIENT REGULATORY OF SUPPLIER OF S	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 66 multiple psychotropic medications and medications for constipation.  483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	TOURISH OF THE PROPOSE OF THE PROPOS	TOPERATION NUMBER:  17E596  17E597  17

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 431	Continued From pag	ge 67	F 4	31		
	by: The facility identified Based on observation interview the facility medication carts, tree room were free of extreatment products.  Findings included:  - Observation from 8:51 A.M. revealed a with an opened date medication room frice Observation from the approximately 9:00 a cart referred to by st cart" contained a bo milligrams used for so of 1/26/14.	the initial tour on 7/9/14 at a vial of tuberculosis vaccine of 4/23/14 located in the lige.  e initial tour on 7/9/14 at A.M. revealed the medication aff as the "regular medication				
	nursing staff H revea	aled the staff should discard cine vial 30 days after the				
		at 9:15 A.M. with direct care staff checked the medication ired medications.				
	nursing staff was resexpired medications remove the expired	at 11:28 A.M. with ng staff D revealed the sponsible for monitoring for . Staff D expected staff to medications from the atment carts, and medication				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E596	B. WING	<del> </del>	07	7/18/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 331 SW OAKLEY TOPEKA, KS 66606		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 431	regarding the storage	provided by the facility of medications revealed be kept on hand after the	F 43	1		
F 441 SS=F	SPREAD, LINENS  The facility must esta Infection Control Property safe, sanitary and co	CONTROL, PREVENT  blish and maintain an gram designed to provide a mfortable environment and evelopment and transmission	F 44	1		
	Program under which (1) Investigates, cont in the facility; (2) Decides what pro should be applied to (3) Maintains a recoractions related to infe (b) Preventing Sprea (1) When the Infection determines that a respresent the spread or isolate the resident. (2) The facility must prommunicable disease from direct contact will train	blish an Infection Control it - rols, and prevents infections cedures, such as isolation, an individual resident; and d of incidents and corrective ections.  d of Infection in Control Program ident needs isolation to f infection, the facility must crohibit employees with a se or infected skin lesions ith residents or their food, if				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTIO AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTIO A. BUILDING			(X3) DATE SURVEY COMPLETED				
		17E596	B. WING		07/18/2014		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 331 SW OAKLEY TOPEKA, KS 66606	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION		
F 441	hand washing is ind professional practice (c) Linens Personnel must han	ect resident contact for which icated by accepted	F 44	1			
	by: The facility identified The sample included observation, record facility failed to main program and failed t	T is not met as evidenced d a census of 48 residents. d 11 residents. Based on review, and interview the tain an infection control o follow proper infection or cleaning residential rooms.					
	- Observation of a ro 8:49 A.M. by housel he/she failed to clea lights and light switch cleaned the toilet se failed to change his/ sweep the bathroom toilet paper on the b sprayed AIR x 75 (a clean rag, wiped down foot boards on the b The surfaces remain drying. Staff Y spray the bathroom and the	com cleaning on 7/15/14 at keeping staff Y revealed in and/or disinfect the call hes. Staff Y wore gloves and at and base of toilet, and her gloves prior to starting to an and placing a new roll of ack of the toilet. Staff Y cleaning product) onto a win the resident's head and ed and the bedside table. The difference wet for 1 minute prior to red the sink and hand rails in en wiped them with a dry rag.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		17E596	B. WING	·····	07/18/2	2014	
	ROVIDER OR SUPPLIER  N PLACE WEST		STREET ADDRESS, CITY, STATE, ZIP CODE  331 SW OAKLEY  TOPEKA, KS 66606				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE CO	(X5) MPLETION DATE	
F 441	only cleaned and sa switches weekly. Sta housekeeping staff of after cleaning the to staff's goal was to for instructions for the products used in the Interview on 7/15/14 administrative nursine expected the house gloves after cleaning hands appropriately housekeeping staff of lights and light switch rooms and not with unsure of the facility lights and light switch expected the house switches and light switch expected the house staff of the switches and light switches are switches and light switches and light switches are switches are switches are switches and light switches are switches and light switches are switches and light switches are switches are switches are switches are switches and light switches are switches are switches and light switches are switches and light switches are switches are switches are switches are switches are switches are	If at 9:12 A.M. with Y revealed the cleaning staff initized the call lights and light aff Y also reported the did not change their gloves lilet. He/she also stated the follow the manufacturer's proper use of the cleaning a facility.	F 44	.1			
	regarding daily patie infection control was cleaning technique.	provided by the facility ent room cleaning revealed s the goal of an effective room follow the manufacturer's					
	instructions for clear change gloves after to clean frequently u	ning products, failed to cleaning the toilet, and failed used surfaces of call lights the resident's room.					
	the facility on 7/15/1	ction control log provided by 4 at approximately 11:00 A.M. used by the facility were not					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		17E596	B. WING _			07/18/2014
	ROVIDER OR SUPPLIER  N PLACE WEST		•	STREET ADDRESS, CITY, STATE, ZIP CO 331 SW OAKLEY TOPEKA, KS 66606	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 441	The forms lacked info completion of antibio facility acquired, and Interview on 7/10/14 administrative nursin reported the infection well, and the facility trending infections.  Interview on 7/15/14 administrative nursin infection control logs thoroughly. Staff D remap to document information to the spread of complete the forms to facility acquired, date the date the infection stated the facility held regarding infection complete the forms to facility acquired, date the date the infection stated the facility held regarding infection control procedure review, stansurance, outbread procedure review, stansurance and procedure facility failed to confection control programmed.	onth from 4/2013 to 7/2014. Cormation regarding tic use, if the infection was if follow up was completed.  at 11:24 A.M. with g staff D revealed he/she in control logs were not done was behind on tracking and at 10:50 A.M. with g staff D revealed the were not completed eported he/she did use a ections in the building to infections but did not so show if the infection was es of antibiotic completion, or a was resolved. He/she also dinservices for all staff control topics such as blood and washing, and isolation provided by the facility on prevention program of the program were k investigation, policy and aff education, and quality	F 4	141		